State of New Jersey

Department of Health and Senior Services
Department of Banking and Insurance

HMO Annual Supplement

_____

Name of HMO

December 31, 2002
Year Ending

Revised: November 2002

State of New Jersey
Department of Health and Senior Services
Department of Banking and Insurance

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Name of HMO	For the Period Ending		
	December	31	, 2002
	Month	Day	Year

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A. STATEMENT BY AN OFFICER OF THE HMO

As an Officer of the HMO, I certify that for the reporting period stated above, the following exhibits, schedules and explanations therein contained, annexed or referred to give a full and true statement of the condition and affairs of the said HMO as of the date stated above, according to the best of my information, knowledge, and belief.

Name	President	Signature	Date
Name	Chief Financial Officer	Signature	Date
Name	Secretary	Signature	Date

B. MANAGED CARE PRODUCT(S) IDENTIFICATION

If the HMO utilizes product name descriptions for various products, report the type(s) of managed care product(s) by identifying the product(s) by placing the name(s) and providing a brief description of the fundamental nature of the product(s) in the appropriate space(s) on the table.

Using the example below, please complete the chart with the proper HMO product names and provide a brief description.

Example	**Managed Care Product(s) Identification**
Product Names	**Description**
Good Choice	Traditional HMO product with mid-range co-pays
Best Choice	Traditional HMO product with low copays
Inexpensive Choice	Traditional HMO with high copays
Open Choice	Point of service (POS) product
Elder Choice	Medicare risk contract program
Freedom Choice	Self-funded POS plan

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Proper Product Name and Brief Description		
Product Names	**Description**	**Counties Served**

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C. (i) SUBSCRIBERS AND MEMBERS BY TYPE OF PAYMENT

Total member months for the year: _____
Average monthly change (Dec. 31 current year minus Dec. 31 prior year membership divided by 12): _____

Type of Prepayment	Subscribers at End of Year*		Total Members at End of Year**
	Subscriber Total	Average Members Per Subscribers	Actual
	(a)	(b)	(c)
A. Group Contracts (Non- Government)			
1. SEHBP Standard Group Plans (2-50 Employee)			
2. Non-Standard Plans (2-50 Employees)			
3. Large Group			
4. Other (Specify)			
B. Individual Contracts			
C. Government Plans			
1. FEHBP			
2. SHBP			
3. Other/Local			
D. Medicare***			
E. Title XIX Medicaid (includes NJ KidCare A)			
F. NJ KidCare Plans B, C & D			
G. NJ Family Care			
H. Subsidized Conversions (N.J.S.A. 17B:27A-4d)			
I. Other (Specify)****			
TOTAL			

Notes: * Subscriber means, in the case of a group contract, an individual whose employment or other status, except family status, is the basis for eligibility for enrollment in the HMO or, in the case of an individual contract, the person in whose name the contract is issued. (N.J.A.C. 8:38-1.2).

** Member means an individual who is enrolled in an HMO. (N.J.A.C. 8:38-1.2).

*** Category relates only to members enrolled in programs complementary to Title XVIII, or under direct cost contracts or risk contracts with the Social Security Administration. Excludes Medicare eligible in other categories.

**** COBRA extension, small group extensions, etc. not reported in other categories.

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C. (ii) MEMBERSHIP BY AGE, GENDER, AND PAYER

Male	**Commercial (1)**				**Medicare (2)**	**DHS Programs (3)**			**Total (1) + (2) + (3)**
	Individual (A)	Small Group (B)	Large Group (C)	Total Commercial (A)+(B)+(C)		Medicaid (Includes NJ KidCare A)	NJ KidCare B, C & D	NJ Family Care	
<3									
3-12									
13-17									
18-19									
20-24									
25-29									
30-34									
35-39									
40-44									
45-49									
50-54									
55-59									
60-64									
65-74									
75-84									
85+									
Total Males									
Average Age									

Note: Include only HMO and HMO P.O.S. members. Do not include self-funded ASO enrollees.
Column headings must not be altered and every blank must be completed. If a column is not applicable, that should be so indicated using "N/A" or "None".

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Female	Commercial (1)				Medicare (2)	DHS Programs (3)			Total (1) + (2) + (3)
	Individual (A)	Small Group (B)	Large Group (C)	Total Commercial (A)+(B)+(C)		Medicaid (Includes NJ KidCare A)	NJ KidCare B, C & D	NJ Family Care	
<3									
3-12									
13-17									
18-19									
20-24									
25-29									
30-34									
35-39									
40-44									
45-49									
50-54									
55-59									
60-64									
65-74									
75-84									
85+									
Total Females									
Average Age									
Male & Female									
Total Age Unknown									
Total Members									
Total Average Age									

Note: Include only HMO and HMO P.O.S. members. Do not include self-funded ASO enrollees. The total members should match total HMO 'In Network Only'. (Column 1) plus 'P.O.S. Option' (Column 2) in Table C (ii) of this report.
Column headings must not be altered and every blank must be completed. If a column is not applicable, that should be so indicated using "N/A" or "None".

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C. (iii) MEMBERSHIP BY COUNTY

	(1) Commercial				(2) Medicare	(3) DHS Programs				TOTAL HMO (1) + (2) + (3)*	Self-Funded
	Individual	Small Group	Large Group	**Total Commercial**		Medicaid (includes NJ KidCare A)	NJ KidCare B, C & D	NJ Family Care	**Total DHS**		
Atlantic											
Bergen											
Burlington											
Camden											
Cape May											
Cumberland											
Essex											
Gloucester											
Hudson											
Hunterdon											
Mercer											
Middlesex											
Monmouth											
Morris											
Ocean											
Passaic											
Salem											
Somerset											
Sussex											
Union											
Warren											
Out of State											
Unknown											
TOTAL											

*The total HMO column should include HMO members in network and HMO P.O.S. members only. Self-Funded should not be included in Total HMO. The total HMO enrollees in this Table should match the totals reported in Table C (iii) and the totals in Column 1 plus 2 of Table C. (ii).

Note: Column headings must not be altered and every blank must be completed. If a column is not applicable, that should be so indicated using "N/A" or "None".

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D. HMO HEALTH SERVICES

1. Number of large group **commercial** HMO Benefit Packages for sale in New Jersey _____.

In determining what constitutes a separate benefit package, use the following guidelines:

(a) A POS plan is a separate benefit package from a pure HMO plan.

(b) An open access plan (full in-network specialist benefits not requiring PCP referral) is a separate benefit package from a plan which requires PCP referral.

(c) Plans using alternate networks are considered separate benefit packages.

(d) Differences in copayments, deductible, coinsurance or numerical benefit caps should not by themselves be treated as separate benefit packages. Such coinsurance differences can be reported on the attached table under “Range of Copayment” and “Limitation on Amount of Service or Benefit” columns.

(e) For POS Plans, prepare a separate table for network services and out of network benefits/services.

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2. For **each** of the Benefit Packages in #1 complete the following:

   a. Number of Members in Package: _____

   b. Is this a POS Plan? Yes _____ No _____

   c. For POS Plans, prepare a separate table for network services and out of network benefits/services

   d. Is self-referral to a network specialist allowed? Yes _____ No _____

      If yes, specify to which specialists self-referral is allowed. (Examples: "All Specialists," only to OB/GYN")

   e. Are enrollees required to select a primary care physician? Yes _____ No _____

Name of Package	Check if Provided	Deductible, Coinsurance and/or Copayment	Range of Limitation on Amount of Service or Benefit
A. Basic Comprehensive Health Services (as defined N.J.A.C. 8:38-5.2)			
1. PCP Physician Services			
2. Diagnostic Laboratory and Radiological Serv.			
3. Prenatal and Obstetric Care			
4. Regular Pediatric Care			
5. Radiation Therapy			
6. Specialist Physician Services			
7. Physical Examinations (Including X-rays and Diagnostic Tests)			
8. Screening Examinations (Including Pap Smears and Mammograms)			
9. Physical Medicine and Rehabilitation Serv.			
10. Diabetes Equipment and Supplies			
11. Eye Care Services			
12. Inpatient Hospital Care			

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Name of Package	Check if Provided	Deductible, Coinsurance and/or Copayment	Range of Limitation on Amount of Service or Benefit
13. Inpatient Psychiatric Care			
14. Inpatient Substance Abuse Care			
15. Outpatient Behavioral Health Services (Including Crisis Intervention)			
16. Outpatient Substance Abuse Care			
17. Services for biologically-based mental illness (as defined at N.J.S.A.26:2J-4.20)			
18. Outpatient Surgical Care			
19. Inpatient Skilled Nursing Care			
20. Home Health Services			
21. Hospice Services			
B. Emergency and Urgent Care Services (as defined at N.J.A.C. 8:38-5.3)			
1. Medical and Psychiatric Emergency and Urgent Care Services			
2. Trauma Services at Level I and Level II Trauma Centers			
3. Out of Services Area Urgent and Emergency Medical Care			
4. Prehospital Care and Hospital Services for Injury of Emergency Illness			
5. Medical Screening Examinations			
C. Supportive Services (as defined at N.J.A.C. 8:38-5.4)			
1. Ambulance Services			
2. Invalid Coach Services			
3. Health Education Services and Diabetic Self-management Education			
4. Medical Social Services			
5. Preventive Health Services Including Family Planning and Infertility Services			

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Name of Package	Check if Provided	Deductible, Coinsurance and/or Copayment	Range of Limitation on Amount of Service or Benefit
D. Health Promotion Programs (as defined at N.J.S.A. 26:2J-4.6(c))			
1. Annual Blood Tests for Hemoglobin, Glucose, Cholesterol Screening Age 20 and Older			
2. Glaucoma Eye Testing Every 5 Years Age 35 and Older			
3. Annual Stool Examinations Age 40 and Older			
4. Colon Examination Every 5 Years Age 45 and Older			
5. Pap Smear Every 2 Years Age 20 and Older			
6. Annual Mammograms Age 40 and Older Baseline Mammography Age 35-40 Years			
7. Recommended Adult Immunizations			
8. Annual Life Style Behavioral Consultation			
E. Wilm's Tumor Treatment (as defined N.J.A.C. 8:38-5.6)			
F. Other Health Services*			
1. Dental			
2. Vision Care			
3. Pharmacy			
4. Chiropractic Care			
5. Alternative Medicine Services (List)			

* May be left blank, filled in with "S" if part of standard benefit package, or filled in with "R" if provided by an optional rider.

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E. PROVIDERS (Including subcontracted services)

1. Network Tables

   a. Complete Table E. (i) - Summary of Providers by County

   b. Complete Table E. (ii) - General Acute Care Hospitals

   c. Complete Table E. (iii) - Summary of Ancillary Providers

2. Provider Directory Available on internet: http//www: _____

3. Turnover of Physician Network During Year

	Number of Physicians at the Start of Reporting Year (1)	Number of those Physicians at the Start of Reporting Year (in Column 1) Who Remained at End of Year (2)	Turnover Rate [1-(2)/(1)]x100%
Primary Care Physicians*			
Obstetrics/Gynecology Physician			
All Other Physicians			
TOTAL			

* Primary care physicians are defined to include: family physicians, general practitioners, pediatricians, and general internists (not obstetricians/gynecologists). Providers are assumed to practice in the clinical area or areas in which they are listed in the health plan's provider directory. (i.e., the provider directory distributed to health plan enrollees) on the first day of the reporting period. If a provider is listed under both a primary care and a specialty area, he/she should only be classified as a primary care physician for purpose of calculating this measure if primary care constitutes the bulk of his/her practice. (i.e., use claims/encounter data, or some other reasonable method, to determine the dominant area of practice).

Calculation of the Measure:

Denominator: Number of PCPs in the health plan network at the start of the reporting years.

Numerator: Number of those PCPs in the health plan network at the start of the reporting period, who remained in the network at the end of the year.

Turnover rate = [1-(numerator/denominator)] x 100%

TABLE E. (i): SUMMARY OF PHYSICIANS BY COUNTY
(INDICATE NUMBER OF PROVIDERS IN EACH COUNTY)

Type of Provider	New Jersey Counties																					
	ATL	BER	BUR	CAM	CAP	CUM	ESS	GLO	HUD	HUN	MER	MID	MON	MOR	OCE	PAS	SAL	SOM	SUS	UNI	WAR	STATE-WIDE
A. PRIMARY CARE PHYSICIANS																						
1. Family Practice																						
2. General Practice																						
3. Internal Medicine																						
4. Pediatrics																						
Subtotal																						
B. SPECIALTY CARE PHYSICIANS																						
1. Cardiologist																						
2. Dermatologist																						
3. Endocrinologist																						
4. Immunologist/Allergist																						
5. Infectious Disease Specialist																						
6. Gastroenterologist																						
7. General Surgeon																						
8. Nephrologist																						
9. Neurologist																						
10. Obstetrician/Gynecologist																						
11. Oncologist/Hematologist																						
12. Ophthalmologist																						
13. Orthopedist																						
14. Oral Surgeon																						
15. Otolaryngologist																						
16. Physiatrist																						
17. Psychiatrist																						
18. Pulmonologist																						
19. Urologist																						
20. Other MD/DO Only (Please Specify)																						
Subtotal																						

TABLE E. (ii): GENERAL ACUTE HOSPITALS		
Note: Sort participating hospitals alphabetically by county and alphabetically within each county. If a hospital has more than one location in the county, make a separate row for each such location.		
Name of Hospital	**County**	*** Date of Initial Contract**

* Report hospitals with a written executed contract with the plan. All other arrangements must be reported on a separate page.

TABLE E. (iii): SUMMARY OF ANCILLARY, TERTIARY AND SPECIALIZED PROVIDERS BY COUNTY (INDICATE NUMBER OF PROVIDERS IN EACH COUNTY)

Type of Provider	New Jersey Counties																					
	ATL	BER	BUR	CAM	CAP	CUM	ESS	GLO	HUD	HUN	MER	MID	MON	MOR	OCE	PAS	SAL	SOM	SUS	UNI	WAR	STATE-WIDE
A. ANCILLARY PROVIDERS 1. Optometrists																						
2. Physical Therapy Centers																						
3. Psychologists																						
4.Occupational Therapy Centers																						
5. Speech Therapy Centers																						
6. Audiology Centers																						
7. Laboratory Centers																						
8. Diagnostic Radiology Centers																						
9. Home Health Agencies																						
10. MRI Centers																						
11. Other (Please Specify)																						
B. TERTIARY AND SPECIALTY																						
1. Level I and II Trauma Centers																						
2. Perinatal Service Facilities																						
3. Tertiary Pediatric Centers																						
4. Inpatient Adult Psychiatric Facilities																						
5. Outpatient Adult Psychiatric Centers																						
6. Inpatient Pediatric Psychiatric Facilities																						

TABLE E. (iii): SUMMARY OF ANCILLARY, TERTIARY AND SPECIALIZED PROVIDERS BY COUNTY (INDICATE NUMBER OF PROVIDERS IN EACH COUNTY) ***Continued***

Type of Provider	New Jersey Counties																					
	ATL	BER	BUR	CAM	CAP	CUM	ESS	GLO	HUD	HUN	MER	MID	MON	MOR	OCE	PAS	SAL	SOM	SUS	UNI	WAR	STATE-WIDE
7. Outpatient Pediatric Psychiatric Service Centers																						
8. Inpatient Rehabilitation Facilities																						
9. Outpatient Rehabilitation Centers																						
10. Inpatient Substance Abuse Facilities																						
11. Outpatient Substance Abuse Centers																						
12. Skilled Nursing Facilities																						
13. Hospice Agencies																						
14. Inpatient Radiation Therapy Centers																						
15. Outpatient Radiation Therapy Ctrs																						
16. Diagnostic Cardiac Catherization Centers																						
Specialty Outpatient Centers:																						
HIV/AIDS Centers																						
Sickle Cell Anemia Centers																						
Hemophilia Centers																						
Craniofacial Centers																						
Congenital Anomalies Centers																						
Renal Dialysis Centers																						

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F. TABLES FOR AMBULATORY UTILIZATION DATA

Definition of an Encounter for use in Completion of Table G.

The basic unit service used in accumulating ambulatory utilization data is the encounter. An encounter is defined as face-to-face contact between a patient and a health care provider resulting in a service to the patient. Each encounter involves a provider who must be acting independently; therefore, the number of encounters for any one patient in any one day is the number of individual providers from whom the patient has received a direct service, including services resulting from referrals by one provider to another provider for consultation or other services.

To meet the encounter criterion, the provider must be acting on his/her own and not just assisting another provider. For example, a nurse assisting a physician during a physical examination by taking a patient's history or by drawing a blood sample, is not credited with a separate encounter, and is simply participating in a physician encounter. However, when a patient comes in periodically for medication or physiological measurements on standing orders of the physician, and these are administered by a nurse, without the physician seeing the patient, this still is to be coded as a physician encounter even though the nurse is the health care provider.

The encounter may be in the center or at any other location as part of the center's outreach or referral program.

Community meetings, such as when a nurse speaks to a high school class on hygiene, are not to be included as encounters.

When a provider treats several members of a family in a single session, each member treated represents an encounter for that provider.

Other group therapy, counseling, or group health sessions such as prenatal classes should be considered encounters.

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F. (i) AMBULATORY ENCOUNTERS BY TYPE AND MEMBERSHIP STATUS

Commercial Table

Table of Ambulatory Encounters	In-Network	Out-of-Network	Total (a)*	Average Number Per Member Per year (b)**
1. Medical Care-Total				
A. Primary Care Physicians				
B. Specialists				
2. Behavioral Health Excluding Substance Abuse Referral and Treatment				
3. Substance Abuse Referral and Treatment				
4. Other Direct Services				
A. Home Health				
B. Emergency Department In-Area				
Out-of-Area				
C. Other (Please Specify)				
5. Ambulatory & Outpatient Surgery				
6. Total Ambulatory Encounters				

* Count each encounter only once and assign to the appropriate category based on the principal services rendered and the reason for the encounter; include only encounters for covered services.

** (a) ÷ average annual membership. The average annual membership is calculated by the member months divided by twelve.

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F. (ii) AMBULATORY ENCOUNTERS BY TYPE AND MEMBERSHIP STATUS

Medicare Table

Table of Ambulatory Encounter	In-Network	Out-of-Network	Total (a)*	Average Number Per Member Per year (b)**
1. Medical Care-Total				
A. Primary Care Physicians				
B. Specialists				
2. Behavioral Health Excluding Substance Abuse Referral and Treatment				
3. Substance Abuse Referral and Treatment				
4. Other Direct Services				
A. Home Health				
B. Emergency Department In-Area				
Out-of-Area				
C. Other (Please Specify)				
5. Ambulatory & Outpatient Surgery				
6. Total Ambulatory Encounters				

* Count each encounter only once and assign to the appropriate category based on the principal services rendered and the reason for the encounter; include only encounters for covered services.

** (a) ÷ average annual membership. The average annual membership is calculated by the member months divided by twelve.

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F. (iii) AMBULATORY ENCOUNTERS BY TYPE AND MEMBERSHIP STATUS

DHS Program Table (Includes Medicaid, KidCare A, B, C, D & Family Care)

Table of Ambulatory Encounter	In-Network	Out-of-Network	Total (a)*	Average Number Per Member Per year (b)**
1. Medical Care-Total				
A. Primary Care Physicians				
B. Specialists				
2. Behavioral Health Excluding Substance Abuse Referral and Treatment				
3. Substance Abuse Referral and Treatment				
4. Other Direct Services				
A. Home Health				
B. Emergency Department In-Area				
Out-of-Area				
C. Other (Please Specify)				
5. Ambulatory & Outpatient Surgery				
6. Total Ambulatory Encounters				

* Count each encounter only once and assign to the appropriate category based on the principal services rendered and the reason for the encounter; include only encounters for covered services.

** (a) ÷ average annual membership. The average annual membership is calculated by the member months divided by twelve.

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G. TABLES FOR INPATIENT UTILIZATION DATA

All utilization for total HMO membership is to be reported whether or not the HMO ultimately bears financial responsibility for the service, except for members' discretionary use of services if the HMO does not arrange or finance these services. For example, Medicare days and C.O.B. (Coordination of Benefits) days should be reported, as the HMO may bear financial responsibility or arrange these services but cosmetic surgery paid for and arranged by the member should not be reported.

Hospital Days incurred on admission should be reported exclusive of same day surgery and out patient procedures. Hospital days incurred should be consistent with financial statements (i.e. inpatient stays overlapping two calendar years should be reported for the year of admission). The day of discharge should not be counted. Do not include same day surgery days. Mother and newborn days should be calculated separately.

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G. (i) UTILIZATION OF INPATIENT SERVICES BY TOTAL MEMBERSHIP

Commercial Table

Type of Inpatient Admission*	Total Admissions		Total Days				
	To Contracting Facility**	To Non-Contracting Facility	In Contracting Facility	In Non-Contract Facility	Total	Per 1,000 Members Per Year	Average Length of Stay
1. Hospital							
A. Medical/Surgical (Acute)							
B. Obstetrical (Maternity)							
C. Newborns***							
D. Behavioral Health Excluding Substance Abuse							
E. Substance Abuse							
F. Comprehensive Rehab							
G. All Other (Define)							
2. Other Facilities							
A. Skilled Nursing Facility							
B. Comprehensive Rehab							
C. Psychiatric Hospitals							
D. All Other (Define)							
Total							

* Primary discharge diagnosis only. If more than one health condition is treated during the hospital stay, the plan should determine the one condition considered to be primary with respect to the hospitalization and report the case accordingly.

** A contracting facility is one that has a written contract with the HMO to provide services for a specified fee or capitation.

*** Newborn days should be reported separately from the mother's days, regardless of hospital billing procedure.

Note: Days hospitalized should be total days before coordination of benefits.

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G. (ii) UTILIZATION OF INPATIENT SERVICES BY TOTAL MEMBERSHIP

Medicare Table

Type of Inpatient Admissions*	Total Admissions		Total Days				
	To Contracting Facility**	To Non-Contracting Facility**	In Contracting Facility	In Non-Contract Facility	Total	Per 1,000 Members Per Year	Average Length of Stay
1. Hospital							
A. Medical/Surgical (Acute)							
B. Behavioral Health Excluding Substance Abuse							
C. Substance Abuse							
D. Comprehensive Rehab							
E. All Other (Define)							
2. Other Facilities							
A. Skilled Nursing Facility							
B. Comprehensive Rehab							
C. Psychiatric Hospitals							
D. All Other (Define)							
Total							

* Primary discharge diagnosis only. If more than one health condition is treated during the hospital stay, the plan should determine the one condition considered to be primary with respect to the hospitalization and report the case accordingly.

** A contracting facility is one that has a written contract with the HMO to provide services for a specified fee or capitation.

Note: Days hospitalized should be total days before coordination of benefits.

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G. (iii) UTILIZATION OF INPATIENT SERVICES BY TOTAL MEMBERSHIP

DHS ProgramTable (Includes Medicaid, KidCare A, B, C, D & Family Care)

Type of Inpatient Admission*	Total Admissions		Total Days				
	To Contracting Facility**	To Non-Contracting Facility	In Con-tracting Facility	In Non-Contract Facility	Total	Per 1,000 Members Per Year	Average Length of Stay
1. Hospital							
A. Medical/Surgical (Acute)							
B. Obstetrical (Maternity)							
C. Newborns***							
D. Behavioral Health Excluding Substance Abuse							
E. Substance Abuse							
F. Comprehensive Rehab							
G. All Other (Define)							
2. Other Facilities							
A. Skilled Nursing Facility							
B. Comprehensive Rehab							
C. Psychiatric Hospitals							
D. All Other (Define)							
Total							

* Primary discharge diagnosis only. If more than one health condition is treated during the hospital stay, the plan should determine the one condition considered to be primary with respect to the hospitalization and report the case accordingly.

** A contracting facility is one that has a written contract with the HMO to provide services for a specified fee or capitation.

*** Newborn days should be reported separately from the mother's days, regardless of hospital billing procedure.

Note: Days hospitalized should be total days before coordination of benefits.

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H. HEALTH CARE FACILITY EXPENSES

Inpatient Services (Incurred Basis*)	Costs of Services Provided	Average Cost Per Day	Average Cost Per Admission
1. Contracting Hospitals Total			
2. Non-Contracting Hospitals Total			
3. Contracting Behavioral Health Facilities			
4. Non-Contracting Behavioral Health Facilities			
5. Contracting Comprehensive Rehab Facilities			
6. Non-Contracting Comprehensive Rehab Facilities			
7. Contracting Substance Abuse Treatment Facilities			
8. Non-Contracting Substance Abuse Treatment Facilities			
9. Contracting SNF Facilities			
10. Non-Contracting SNF Facilities			
11. Total Inpatient Services (exclude ER Services)			
Outpatient Services (Incurred Basis*)			
12. Contracting Hospitals			
13. Non-Contracting Hospitals			
14. Contracting Behavioral Health Facilities			
15. Non-Contracting Behavioral Health Facilities			
16. Contracting Substance Abuse Treatment Facilities			
17. Non-Contracting Substance Abuse Treatment Facilities			
18. Contracting Comprehensive Rehab Facilities			
19. Non-Contracting Comprehensive Rehab Facilities			
20. Total Outpatient Services			

* "Incurred basis" means paid claims plus an appropriate change in reserves for the prior year. The date a claim is "incurred" for hospitalization is the date of admission. The period of a single claim incurred is the date of admission until the day prior to discharge. This should be consistent with the entry in the NAIC Report #2.

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H. HEALTH CARE FACILITY EXPENSES (Continued)

Inpatient Services (Incurred Basis*)	Costs of Services Provided	Average Cost Per Day	Average Cost Per Admission
21. Contracting Hospitals			
22. Non-Contracting Hospitals			
23. Total Emergency Services			
Total Health Care Facility Expenses (Items 9, 16 and 19)			

* "Incurred basis" means paid claims plus an appropriate change in reserves for the prior year. The date a claim is "incurred" for hospitalization is the date of admission. The period of a single claim incurred is the date of admission until the day prior to discharge. This should be consistent with the entry in the NAIC Report #2.

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I. MEDICAL EXPENSES BY TYPE OF PAYMENT

Expense	Capitation		Fee for Service		Total Amount
	Direct	Subcontracted	Direct	Subcontracted	
1. Primary Care Physicians					
2. Referral/Specialist Physicians					
3. Oral Surgeons					
4. Podiatrists					
5. Optometrists					
6. Behavioral Health Excluding Substance Abuse Referral and Treatment					
7. Substance Abuse Referral and Treatment					
8. Laboratory*					
9. Radiology*					
10. Pharmacy					
11. Hospital (Inpatient)**					
12. Hospital (Outpatient)**					
13. Other Individual Provider (Specify)					
14. Totals					

*Expenses not included in physician expense category.
**Facility charge only.

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J. ANALYSIS OF MINIMUM NET WORTH REQUIREMENTS

	Prior Quarter 4	Prior Quarter 3	Prior Quarter 2	Latest Quarter	Total
(a) $1,207,319*	=======	=======	=======	=======	=======
(b) Premium Revenues**					
First $150,000,000 at 2%	_____	_____	_____	_____	_____
Over $150,000,000 at 1%	_____	_____	_____	_____	_____
Total	=======	=======	=======	=======	=======
(c) Three Months' Uncovered Expenditure	=======	=======	=======	=======	=======
(d) (i) 8% of Fee for Service and Hospital Non Contracted Costs	_____	_____	_____	_____	_____
(ii) 4% of Contracted Hospital Costs	_____	_____	_____	_____	_____
Total of (i) and (ii)	=======	=======	=======	=======	=======

Minimum Net Worth Requirement = Maximum of Total Column in (a), (b), (c) or (d)	= = = = = = =
Actual Net Worth as of the period ending date (from Report #1 – Part B)	= = = = = = =
Net Surplus/(Deficit***)	= = = = = = =
125% of Minimum Requirement	= = = = = = =
Net Surplus/(Deficit***) at 125%	

* Adjusted annually for inflation per N.J.A.C. 8:38-11.1(b).

** Premium Revenue is based on Report #2 of the NAIC Financial Statement.

*** A deficit requires a detailed plan of action, subject to the review and approval of the Commissioner of Banking and Insurance, demonstrating how and when the minimum net worth will be re-established and maintained. This discussion must include possible alternate funding sources, including invoking of parental guarantees, etc. [N.J.A.C. 8:38-11.6(f)]

"Covered" expenditures only refer to capitations paid directly to rendering providers or traditional IPAs. Physicians on salary shall be considered capitated for this calculation.

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K. MEMBER COMPLAINT PROCESS

(As defined at N.J.A.C. 8:38-3.7)

Instructions

For purposes of the Annual Supplement, a "complaint" is defined as an expression of dissatisfaction with any aspect of the HMO's health care services, including, but not limited to, quality of care, choice and accessibility of providers, and network adequacy. Do **not** include general inquiries from members as a complaint.

Please report a complaint only **ONCE**. Complaints reported in this section should **NOT** involve issues of medical necessity or matters that proceed to the utilization management appeal process due to the denial of health care services. The Departments recognize, however, that in some cases, a complaint may initially appear to be resolvable through Member Services but later be determined to involve a question of medical necessity. Accordingly, a column has been included for reporting the number of complaints forwarded to the utilization management appeal process.

Complete Table I (a) and (b) for all **written and verbal complaints** received from HMO **commercial members** concerning any aspect of the HMO's health care services **except behavioral health and substance abuse treatment services**. Separate tables have been provided for reporting of behavioral health and substance abuse treatment service complaints and utilization management appeals.

1. Report the number of complaints in Table I (a) below:

TABLE I (a)
NUMBER OF MEMBER COMPLAINTS

Number of Unresolved Complaints in Progress at Start of Year	Number of New Complaints During the Year	*Number of Complaints **Resolved** During the Year	Percentage of Complaints Resolved within 30 days	Number of Unresolved Complaints at End of Year	Number of Complaints Forwarded to UM Appeal Process

* The number of complaints resolved should be the same in Table I (a) and Table I (b).

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K. MEMBER COMPLAINTS BY CATEGORY (Continued)

2. Report the number of complaints resolved during the year, by category. In completing the table, select the one category that most accurately reflects the nature of each resolved complaint, even when more than one category could be considered applicable.

TABLE I (b)
CATEGORIES OF MEMBER COMPLAINTS

Number of Complaints	Percentage of Complaints	Categories of Complaints
		Appointment Availability, PCP
		Appointment Availability, Specialist
		Appointment Availability, Other type of provider
		Waiting Time Too Long at Office, PCP
		Waiting Time Too Long at Office, Specialist
		Dissatisfaction with Quality of Medical Care, PCP
		Dissatisfaction with Quality of Medical Care, Specialist
		Dissatisfaction with Quality of Medical Care, Hospital
		Dissatisfaction with Quality of Medical Care, Other type of provider
		Difficulty in Obtaining Access to a Health Care Professional after Hours
		Difficulty Related to Obtaining Emergency Services
		Dissatisfaction with Dental Services
		Dissatisfaction with Vision Services
		Dissatisfaction with Ancillary Services (home health, DME, therapy, etc.)
		Dissatisfaction with Plan Benefit Design
		Dissatisfaction with Provider Office Administration
		Dissatisfaction with Marketing, Member Services, Member Handbook, etc.

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K. MEMBER COMPLAINTS BY CATEGORY (continued)

TABLE I (b)
CATEGORIES OF MEMBER COMPLAINTS

Number of Complaints	Percentage of Complaints	Categories of Complaints
		Dissatisfaction with Utilization Management Appeal Process
		Denial of Clinical Treatment for Covered Service
		Dissatisfaction with Provider Network
		Difficulty in Obtaining Referral to Network Specialist of Member's Choice
		Difficulty in Obtaining Referrals for Ancillary Services (Home Health, DME, etc.)
		Difficulty in Obtaining Referrals for Covered Services - Eye Care
		Difficulty in Obtaining Referrals for Covered Services - Dental Services
		Difficulty with Plan Policies Regarding Specialty Referrals
		Laboratory Issues
		Pharmacy/Formulary Issues
		Reimbursement Problems/Unpaid Claims
		Administrative Denials
		Referral or Authorization Not Obtained
		Member Not Covered at Time of Service
		Service Not Covered
		Timeliness of Notification to HMO
		Other (Define)
	100%	*Total number of complaints **resolved** during the year

*The number of complaints resolved should be the same in Table I (a) and (b).

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K. (i.) MEMBER COMPLAINTS - BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Complete Table II (a) for all **written and verbal complaints** received from HMO **commercial members** concerning **behavioral health.**

TABLE II (a)
NUMBER OF MEMBER BEHAVIORAL HEALTH COMPLAINTS

Number of Unresolved Complaints in Progress at Start of Year	Number of New Complaints During the Year	*Number of Complaints **Resolved** During the Year	Percentage of Complaints Resolved within 30 days	Number of Unresolved Complaints at End of Year	Number of Complaints Forwarded to UM Appeal Process

Complete Table II (b) for all **written and verbal complaints** received from HMO **commercial members** concerning **substance abuse treatment services.**

TABLE II (b)
NUMBER OF MEMBER SUBSTANCE ABUSE TREATMENT COMPLAINTS

Number of Unresolved Complaints in Progress at Start of Year	Number of New Complaints During the Year	*Number of Complaints **Resolved** During the Year	Percentage of Complaints Resolved within 30 days	Number of Unresolved Complaints at End of Year	Number of Complaints Forwarded to UM Appeal Process

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K. (i) MEMBER COMPLAINTS BY CATEGORY - BEHAVORIAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Report the number of complaints concerning **behavioral health and substance abuse treatment services** resolved during the year by category. In completing the table, select the one category that most accurately reflects the nature of each resolved complaint, even if more than one category could be considered applicable.

TABLE II (c)
CATEGORIES OF MEMBER BEHAVIORAL HEATLH & SUBSTANCE ABUSE TREATMENT SERVICES COMPLAINTS

Behavioral Health Complaints		Substance Abuse Treatment Complaints		Categories of Complaints
Number	Percent	Number	Percent	
				Appointment Availability, Psychologist
				Appointment Availability, Psychiatrist
				Appointment Availability, Other type of provider
				Waiting Time Too Long at Office
				Dissatisfaction with Quality of Medical Care, Inpatient
				Dissatisfaction with Quality of Medical Care, Other type of provider
				Difficulty in Obtaining Access to a Health Care Professional After Hours
				Difficulty Related to Obtaining Emergency Services
				Dissatisfaction with Plan Benefit Design
				Dissatisfaction with Provider Office Administration
				Dissatisfaction with Marketing, Member Services or Handbook,
				Dissatisfaction with Utilization Management Appeal Process
				Dissatisfaction with Provider Network
				Difficulty in Obtaining Referral to Network Specialist of Member's Choice
				Difficulty in Obtaining Referrals for Covered Services
				Difficulty with Plan Policies Regarding Specialty Referrals
				Pharmacy/Formulary Issues
				Reimbursement Problems/Unpaid Claims

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K. (i) MEMBER COMPLAINTS BY CATEGORY - BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT (continued)

Behavioral Health Complaints		Substance Abuse Treatment Complaints		Categories of Complaints
Number	Percent	Number	Percent	
				Administrative Denials
				Referral or Authorization Not Obtained
				Member Not Covered at Time of Service
				Service Not Covered
				Timeliness of Notification to HMO
				Other (Define)
		100%	100%	*Total number of complaints **resolved** during the year

*The number of complaints **resolved** should be the same as reported per service in Table II (a) and (b).

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L. PROVIDER COMPLAINT PROCESS

(As defined at N.J.A.C. 8:38-3.7)

Complete the following tables for all **written and verbal complaints** received from HMO providers:

1. Report the number of provider complaints in the table below:

NUMBER OF PROVIDER COMPLAINTS

Number of Unresolved Complaints in Progress at Start of Year	Number of New Complaints During the Year	*Number of Complaints Resolved During the Year	Number of Unresolved Complaints at End of Year

2. Report the number of complaints resolved during the year by category in the table below:

CATEGORIES OF PROVIDER COMPLAINTS

Number of Complaints	Percentage of Complaints	Categories of Complaints
		Claim issues (reimbursement, timeliness, resubmission); PCP
		Claim issues (reimbursement, timeliness, resubmission); Specialist
		Claim issues (reimbursement, timeliness, resubmission); Hospital
		Claim issues (reimbursement, timeliness, resubmission); Other Provider
		Complexity of Administrative Process
		Difficulty Obtaining Prompt Authorization for Needed Medical Services
		Credentialing/Recredentialing
		Termination
		Dissatisfaction with Provider Manual
		Dissatisfaction with Responsiveness of Provider Services
		Dissatisfaction with UM Appeal Process/Medical Mgmt Guidelines
		Dissatisfaction with Provider Network
		Coordination of Benefits
		Other (Define)
	100%	*Total number of complaints resolved during the year

*The number of complaints resolved should be the same in both tables.

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M. UTILIZATION MANAGEMENT

1. Report the total number of denials of a covered health service issued, either verbally or in writing, during the year:_____
2. Complete the following table for denials of inpatient admissions and days during the year:

	Total Admissions Denied						**Total Inpatient Days Denied**					
Type of Inpatient Admission	To Contracting Facility			To Non-Contracting Facility			In Contracting Facility			In Non-Contracting Facility		
	Commercial	Medicare	Medicaid	Commercial	Medicare	Medicaid	Commercial	Medicare	Medicaid	Commercial	Medicare	Medicaid
HOSPITAL												
Medical/Surgical (Acute)												
Obstetrical (Maternity)												
Newborn												
Behavioral Health **Excluding** Substance Abuse												
Substance Abuse												
Comprehensive Rehab												
All Other (Define)												
OTHER FACILITIES												
Skilled Nursing Facility												
Comprehensive Rehab												

M. UTILIZATION MANAGEMENT (Continued)

Type of Inpatient Admission	Total Admissions Denied						Total Inpatient Days Denied					
	To Contracting Facility			To Non-Contracting Facility			In Contracting Facility			In Non-Contracting Facility		
	Commercial	Medicare	Medicaid	Commercial	Medicare	Medicaid	Commercial	Medicare	Medicaid	Commercial	Medicare	Medicaid
Psychiatric Hospitals												
All Other (Define)												
Total Denials												

Note: Days hospitalized should be total days before coordination of benefits.

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N. INTERNAL UTILIZATION MANAGEMENT APPEAL PROCESS (as defined at N.J.A.C. 8:38-8)

1. Attach a description of the two-stage internal Utilization Management Appeal Process and a copy of the denial letters issued after a Stage I and Stage II denial.

Complete the following tables for denials of any service, **except formulary, behavioral health and substance abuse treatment,** appealed through the internal utilization management appeals process. Separate tables have been provided for reporting formulary, behavioral health and substance abuse treatment internal appeals.

2. Report the number of Stage I and Stage II appeals* filed by members or by providers acting on behalf of members with the member's consent in Table I below:

TABLE I
NUMBER OF STAGE I AND STAGE II APPEALS

Number of Stage I Appeals in Progress at Start of Year	Number of New Stage I Appeals During the Year	Number of Stage I Appeals Completed During the Year	Number of Stage I Appeals in Progress at End of Year
Number of Stage II Appeals in Progress at Start of Year	**Number of New Stage II Appeals During the Year**	**Number of Stage II Appeals Completed During the Year**	**Number of Stage II Appeals in Progress at End of Year**

3. Report the outcome of all completed Stage I and Stage II appeals completed during the year below:

TABLE II
RESOLUTION OF STAGE I AND II APPEALS

Stage I Appeals					
(1) Denial Upheld	(2) Denial Reversed	(3) Denial Modified	*Total (1+2+3)	% Modified or Reversed	Number of Stage I Appeals Forwarded To Stage II
Stage II Appeals					
(1) Denial Upheld	(2) Denial Reversed	(3) Denial Modified	*Total (1+2+3)	% Modified or Reversed	

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N. INTERNAL UTILIZATION MANAGEMENT APPEALS BY CATEGORY

4. Report the number of completed Stage I and Stage II appeals, by category, in the table below:

CATEGORIES OF STAGE I AND II APPEALS

Number of Stage I Appeals	%	Number of Stage II Appeals	%	Categories of Appeals
				Denial of in-patient hospital days
				Reduction of acuity level (inpatient)
				Denial of surgical procedure
				Denial of emergency services
				Denial of outpatient medical treatment/diagnostic testing
				Denial of outpatient rehabilitation therapy (PT, OT, Cardiac, Speech, etc.)
				Denial of home health care
				Denial of hospice care
				Denial of skilled nursing facility
				Denial of medical equipment (DME) and/or supplies
				Denial of referral to out-of-network specialist
				Service not a covered benefit
				Service considered experimental/investigational
				Service considered cosmetic, not medically necessary
				Service considered dental, not medically necessary
				Other (Define):
	100%		100%	Total number of Appeals Resolved

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N. EXTERNAL UTILIZATION MANAGEMENT APPEAL PROCESS

Complete the following tables for external appeals, **except formulary, behavioral health and substance abuse treatment**, reviewed by the IURO:

(a) Report the number of IURO case decisions received from the IURO below:

TABLE III (a)
NUMBER OF EXTERNAL APPEALS

Number of Cases Under Review by IURO at Start of Year	Number of IURO Decisions **Received** by Plan During the Year	Number of Cases Remaining Under Review by IURO at End of Year

(b) Report the resolution of IURO cases received during the year below:

TABLE III (b)
RESOLUTION OF EXTERNAL APPEALS

IURO Decision		
Denial Upheld	Denial Reversed	Denial Modified

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N. EXTERNAL UTILIZATION MANAGEMENT APPEALS BY CATEGORY

(c) Report the number of IURO decisions received during the year by category:

CATEGORIES OF EXTERNAL APPEALS

Number of Appeals	Percentage	Categories of Appeals
		Denial of in-patient hospital days
		Reduction of acuity level (inpatient)
		Denial of surgical procedure
		Denial of emergency services
		Denial of outpatient medical treatment/diagnostic testing
		Denial of outpatient rehabilitation therapy (PT, OT, Cardiac, Speech, etc.)
		Denial of requested prescription drug
		Denial of home health care
		Denial of hospice care
		Denial of skilled nursing facility
		Denial of medical equipment (DME) and/or supplies
		Denial of referral to out-of-network specialist
		Service not a covered benefit
		Service considered experimental/investigational
		Service considered cosmetic, not medically necessary
		Service considered dental, not medically necessary
		Other (Define):
	100%	*Total

*Number should be the same as from Table III (a).

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N. (i) INTERNAL UTILIZATION MANAGEMENT APPEAL PROCESS - FORMULARY APPEALS

Report the number of Stage I and Stage II **formulary** appeals filed by members or by providers acting on behalf of members with the member's consent below:

NUMBER OF FORMULARY APPEALS

Number of Stage I Appeals in Progress at Start of Year	Number of New Stage I Appeals During the Year	Number of Stage I Appeals Completed During the Year	Number of Stage I Appeals in Progress at End of Year
Number of Stage II Appeals in Progress at Start of Year	**Number of New Stage II Appeals During the Year**	**Number of Stage II Appeals Completed During the Year**	**Number of Stage II Appeals in Progress at End of Year**

Report the outcome of all Stage I and Stage II appeals completed during the year below:

RESOLUTION OF FORMULARY APPEALS

Stage I Formulary Appeals					
(1) Denial Upheld	(2) Denial Reversed	(3) Denial Modified	*Total (1+2+3)	% Modified or Reversed	Number of Stage I Appeals Forwarded to Stage II
Stage II Formulary Appeals					
(1) Denial Upheld	(2) Denial Reversed	(3) Denial Modified	*Total (1+2+3)	% Modified or Reversed	

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N. (i) EXTERNAL APPEAL PROCESS - FORMULARY APPEALS

Complete the following tables for external **formulary** appeals reviewed by the IURO:

(a) Report the number of IURO case decisions received from the IURO below:

NUMBER OF EXTERNAL FORMULARY APPEALS

Number of Cases Under Review by IURO at Start of Year	Number of IURO Decisions **Received** by Plan During the Year	Number of Cases Remaining Under Review by IURO at End of Year

(b) Report the resolution of IURO cases received during the year below:

RESOLUTION OF EXTERNAL FORMULARY APPEALS

IURO Decision		
Denial Upheld	Denial Reversed	Denial Modified

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N. (ii) INTERNAL UTILIZATION MANAGEMENT APPEAL PROCESS – BEHAVIORAL HEALTH

1. If the two-stage internal Utilization Management Appeal Process is in any way different than the Utilization Management appeal process described earlier, attach a description of the process and a copy of the denial letters issued after a Stage I and Stage II denial. Please identify any stage of the appeal process delegated to a subcontractor.

(a) Report the number of Stage I and Stage II appeals of behavioral health services filed by members or by providers acting on behalf of members with the member's consent in the table below:

NUMBER OF BEHAVIORAL HEALTH APPEALS

Number of Stage I Appeals in Progress at Start of Year	Number of New Stage I Appeals During the Year	Number of Stage I Appeals Completed During the Year	Number of Stage I Appeals in Progress at End of Year
Number of Stage II Appeals in Progress at Start of Year	**Number of New Stage II Appeals During the Year**	**Number of Stage II Appeals Completed During the Year**	**Number of Stage II Appeals in Progress at End of Year**

(b) Report the outcome of all Stage I and Stage II appeals completed during the year in the table below:

RESOLUTION OF BEHAVIORAL HEALTH APPEALS

Stage I Appeals					
(1) Denial Upheld	(2) Denial Reversed	(3) Denial Modified	*Total (1+2+3)	% Modified or Reversed	Number of Stage I Appeals Forwarded to Stage II
Stage II Appeals					
(1) Denial Upheld	(2) Denial Reversed	(3) Denial Modified	*Total (1+2+3)	% Modified or Reversed	

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N. (iii) INTERNAL UTILIZATION MANAGEMENT APPEAL PROCESS - SUBSTANCE ABUSE TREATMENT SERVICES (Continued)

(a) Report the number of Stage I and Stage II appeals of substance abuse treatment services filed by members or by providers acting on behalf of members with the member's consent in the table below:

NUMBER OF SUBSTANCE ABUSE TREATMENT SERVICES APPEALS

Number of Stage I Appeals in Progress at Start of Year	Number of New Stage I Appeals During the Year	Number of Stage I Appeals Completed During the Year	Number of Stage I Appeals in Progress at End of Year
Number of Stage II Appeals in Progress at Start of Year	**Number of New Stage II Appeals During the Year**	**Number of Stage II Appeals Completed During the Year**	**Number of Stage II Appeals in Progress at End of Year**

(b) Report the outcome of all Stage I and Stage II appeals completed during the year in the table below:

RESOLUTION OF SUBSTANCE ABUSE TREATMENT APPEALS

Stage I Appeals					
(1) Denial Upheld	(2) Denial Reversed	(3) Denial Modified	*Total (1+2+3)	% Modified or Reversed	Number of Stage I Appeals Forwarded to Stage II
Stage II Appeals					
(1) Denial Upheld	(2) Denial Reversed	(3) Denial Modified	*Total (1+2+3)	% Modified or Reversed	

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N. (iv.) INTERNAL UTILIZATION MANAGEMENT APPEALS BY CATEGORY - BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREAMENT SERVICES

Report the number of completed Stage I and Stage II appeals, by category, in the table below:

CATEGORIES OF STAGE I AND II APPEALS

Behavioral Health Stage I Appeals Number	Percent	Behavioral Health Stage II Appeals Number	Percent	Substance Abuse Stage I Appeals Number	Percent	Substance Abuse Stage II Appeals Number	Percent	Categories of Behavioral Health and Substance Abuse Treatment Services Appeals
								Denial of in-patient hospital days
								Reduction of acuity level
								Denial of emergency services
								Denial of referral to out-of-network specialist
								Service not a covered benefit
								Other (Define):
	100%		100%		100%		100%	Total number of Appeals Resolved

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N. (v) EXTERNAL UTILIZATION MANAGEMENT APPEALS - BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES

Complete the following tables for external appeals reviewed by the IURO:

(a) Report the number of case decisions received from the IURO below:

TABLE III (a)
NUMBER OF EXTERNAL BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES APPEALS

Number of Cases Under Review by IURO at Start of Year		Number of IURO Case Decisions **Received** by Plan During the Year		Number of Cases Remaining Under Review by IURO at End of Year	
*BH	*SA	BH	SA	BH	SA

(b) Report the resolution of IURO cases below:

TABLE III (b)
RESOLUTION OF EXTERNAL BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES APPEALS

IURO Decision					
Denial Upheld		Denial Reversed		Denial Modified	
*BH	*SA	BH	SA	BH	SA

* BH: Behavioral Health SA: Substance Abuse Treatment Services

State of New Jersey
Department of Health and Senior Services
Department of Banking and Insurance

HMO ANNUAL SUPPLEMENT

Name of HMO

For the Period Ending
December 31, 2002
Month Day Year

N. (v) EXTERNAL UTILIZATION MANAGEMENT APPEALS BY CATEGORY - BEHAVIORAL HEALTH AND SUBSTANCE AND ABUSE TREATMENT SERVICES

(c) Report the number of IURO case decisions received during the year:

TABLE III (c)
CATEGORIES OF EXTERNAL BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES APPEALS

Behavioral Health Appeals Number	Behavioral Health Appeals Percent	Substance Abuse Appeals Number	Substance Abuse Appeals Percent	Categories of Appeals
				Denial of in-patient hospital days
				Reduction of acuity level
				Denial of surgical procedure
				Denial of emergency services
				Other (Define):
	100%		100%	*Total

* Number should be the same as from Table III (a).

State of New Jersey
Department of Health and Senior Services
Department of Banking and Insurance

Name of HMO	For the Period Ending
	December 31, 2002
	Month Day Year

O. CONTINOUS QUALITY IMPROVEMENT

1. Submit a copy of the reports from the continuous quality improvement plan submitted to the Board of Directors as required at N.J.A.C. 8:38-3.8(c)2.

2. Identify clinical activities monitored for quality improvement during the year and interventions implemented.